



NEW LICENSE APPLICATION
ADVISORY COMMITTEE ON ANESTHESIOLOGIST ASSISTANTS
BOARD OF MEDICINE

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at 1-888-204-6193, Monday through Friday, 8AM to 5PM EST. A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 1. REQUESTED LICENSE TYPE/FEEs (includes non-refundable application fee – see instructions)

☐ AA – Anesthesiologist Assistant by Endorsement \$176.00

☐ Duplicate Registered License Print (limit 5) ____ X \$26.00 = \$ ____ .00

Total Enclosed \$ ____ .00

MAIL TO:
Department of Health
Health Professional Licensing
Administration
Advisory committee on Anesthesiologist
Assistants
717 – 14th Street, NW, Suite 600
Washington, DC 20005

Walk-in Service
Monday through Friday, 9am to 4pm
717 – 14th Street, NW, Suite 600
Washington, DC 20005

Make check or money order payable to:

Promissor, Inc.

HPLA ONLY

Check \$

Check #

Staff

\$ ____ .00

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME MI LAST NAME SUFFIX
(Jr, Sr, etc.)

SOCIAL SECURITY NUMBER

if applicant does not provide a social security number, a sworn affidavit is required.

M M D D Y Y Y Y

DATE OF BIRTH

PLACE OF BIRTH

Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female

GENDER

Please check the correct box.

Section 2A. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX
(Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION

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Section 5. POSTGRADUATE WORK EXPERIENCE

List all work experience since graduation from college, university and professional school, in reverse chronological order, beginning with the most recent.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below)*	Full Time	Part Time

*** TYPE OF POSITION KEY**

- | | |
|---------------------------------|---|
| A. Employment | E. Internship |
| B. Private Practice | F. Other (specify on separate sheet of paper) |
| C. Clinical Rotations Practicum | |
| D. Instructor / Supervisor | |

Section 6A. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license. Provide letters of verification all jurisdictions regardless if they are active, inactive or expired.

Jurisdiction	Date License Was First Obtained	License Number

SECTION 6B. SUPPORTING DOCUMENTS REQUIRED

Please indicate the supporting documents you have included with this package **or** requested to be sent to the Board of Professional Counseling. Keep a photocopy of all supporting documents for your records.

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	YES	NO	
A. Completed and signed application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Two recent and identical passport-type photos of the applicant's face (approx. 2"x2") with applicant's name printed on the back. <u>The photos must be original photos and cannot be computer-generated copies or paper copies.</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Submit one (1) clear photocopy of a government issued photo ID , such as your valid driver's license, as proof of identity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Official transcript (with seal) may be sent directly from the AA school, but is preferred that it accompanied the application in a sealed envelope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Submit documentation of current certification from NCCAA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. A letter of verification from all jurisdictions where the applicant was ever licensed as AA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Copies of legal documents supporting all name changes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J below, you must provide full information and complete details **on a separate sheet of paper, including copies of relevant court documents**, and attach to this application.

**HPLA
ONLY**

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

Yes No
☐ ☐

- A.
1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
 4. Past due taxes;
 5. Past due District of Columbia Water and Sewer Authority service fees; or
 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

YES NO
☐ ☐

B. Have you ever been convicted or investigated of a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C. Are you now or have you ever been registered or licensed in DC or any other state/jurisdiction? (<i>If "Yes," be sure to complete section 6C of this form.</i>)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D. Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E. Have you ever voluntarily surrendered a license or registration certificate after formal charges have been filed against you or while under investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F. Have you ever been terminated from or resigned from a clinical or professional training program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G. Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H. Has the use of drugs and/or alcohol resulted an impairment of your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I. (1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J. Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
K. Have you ever been censured or found guilty of any unethical practices by a state or private license, certification board, or a professional organization of which you were a member? If yes, please explain on supplement sheet.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE

NAME (Please Print)

DATE

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To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.